

SPEAKER 1: This is a 73-year-old lady who was referred for independent assessment and recommendations regarding her newly diagnosed bladder cancer. The patient has the expected comorbidities of a lady in her 70's. This is her first diagnosis of bladder cancer. She was deemed by her outside urologist to have unresectable disease.

Her outside pathology revealed only low grade TA disease. A cystectomy was considered before referral for reresection. Considering the patient's age and comorbidities, it would seem an over treatment to perform a radical cystectomy and urinary diversion for simply low grade TA disease.

At the time of reresection, we performed a complete cystoscopy. It revealed multifocal diffuse disease in the patient's bladder. Most of the disease was focused on the left base and left lateral wall.

As you can see from the prior resection site, it was very close to her left ureteral orifice. The patient's right kidney is atrophic from a prior open left ureteral lithotomy. We begin by taking a biopsy of a representative lesion to provide grade information for the patient's tumor.

Once we have our biopsy, we then begin vaporization. Using the button electrode, we start with the bulk of the tumor on the patient's left lateral wall. As you can see from resection, the creation of bubbles indicates efficient and effective vaporization of the tumor. We proceed in this manner for a period of time to have a complete vaporization of the patient's tumor burden.

One of the benefits of the button electrode is that vaporization proceeds with very minimal blood loss. Furthermore, we can vaporize in a forward and backward manner. In other words, whereas a loop electrode only resects coming toward the scope, we can vaporize with the electrode as it is brought toward the scope and away from the scope.

As you can see, we have been vaporizing for a significant period of time. We are now coming down toward the base of the largest tumor. There is excellent hemostasis. Visualization has been optimal throughout vaporization.

One of the benefits of the vaporization is that there is not a char that is created on the electrode itself. Furthermore, the tissue does not become so charred that it is difficult to continue the vaporization.

As you can see, we have been vaporizing for a long period of time, and we now have almost completely vaporized the tumor in total. It is very careful to remember that the electrode on the cutting current can vaporize through the wall of the bladder. As us, one must continue to be careful as one reaches the base, and to be cognizant of the efficiency and power of the bipolar button electrode itself.

Once we have completed vaporization of the main tumor, we then turn to the smaller tumors that are throughout the bladder. Vaporization proceeds in a very efficient and expeditious manner with these smaller tumors. Deep biopsies of the tumor base are then taken. This will help to ensure that accurate staging information is provided to the pathologist.

Although in contrast to a traditional TURBT, we do not provide as much tissue to the pathologist for pathological review. We have not had any difficulty obtaining our accurate stage information in order to appropriately treat these patients.

We then use the bipolar electrode to obtain hemostasis in the usual manner. The configuration of the button is much more efficient at achieving hemostasis and to reaching the edges of the tumor resection as compared to a right angle loop electrode.

As you can see, we had a complete tumors resection of all tumors. Hemostasis is excellent. This patient's pathology was all low grade TA disease. We were able to obtain accurate stage and grading information.

The patient did well post operatively, with complete resolution of her lower urinary tract symptoms. She has been seen in follow up with minimal residual disease at her repeat TURBT. She has not any evidence of stage progression. She continues to be followed endoscopically according to AUA guidelines.